

# GIC RETIREE/SURVIVOR ENROLLMENT/CHANGE FORM (FORM-RS)



REQUIRED INFORMATION					
REQUIRED	Insured Information	GIC-ID (usually Soc. Sec. #)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Dept. ID # or Agency/Division # /
		Name – Last		First	MI
REQUIRED	Address	Street		City	State Zip
		Contact Information	Home Phone ( )	Cell Phone ( )	Email
REQUIRED	Claim Number	Insured's Medicare Claim #		Spouse's Medicare Claim #	

Retirement Information	Name of State Agency or Municipality retired from	Do you receive a monthly pension from a public retirement system? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Retirement / /
Survivor Information	Name of Deceased Employee or Retiree	Deceased Employee's/Retiree's Soc. Sec. # - -	Have you remarried? <input type="checkbox"/> Yes Date of remarriage ___/___/___ <input type="checkbox"/> No

REQUIRED	<b>Select all that apply:</b>		<b>Qualifying Status Change</b>	Date of Event: ___ / ___ / _____
	<input type="checkbox"/> New Enrollment (New Eligibility) <input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Dropping Dependent(s) <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change <input type="checkbox"/> Annual Enrollment <input type="checkbox"/> Decline all GIC coverage		<input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Change in Dependent Eligibility Status <input type="checkbox"/> Moved out of health plan's service area	<input type="checkbox"/> Gain of Other Coverage <input type="checkbox"/> Involuntary Loss of Other Coverage <input type="checkbox"/> Death of spouse/dependent <input type="checkbox"/> Spouse's Annual Enrollment

MEDICARE PLAN – Select one if you and/or your spouse/covered dependents are enrolled in Medicare.			Effective Date: / /
<input type="checkbox"/> Fallon Senior Plan (HMO) <input type="checkbox"/> Harvard Pilgrim Medicare Enhance (Indemnity) <input type="checkbox"/> Health New England MedPlus (HMO) <input type="checkbox"/> Tufts Medicare Complement (HMO)	<input type="checkbox"/> Tufts Medicare Preferred (HMO) <input type="checkbox"/> UniCare State Indemnity Medicare Extension CIC: <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Medicare Coverage Election</b> <input type="checkbox"/> Individual <input type="checkbox"/> Individual and spouse <input type="checkbox"/> Family	Check all that apply: <input type="checkbox"/> Individual on Medicare <input type="checkbox"/> Spouse on Medicare <input type="checkbox"/> Dependent(s) on Medicare

NON-MEDICARE PLAN – Select one if you and/or your spouse/covered dependents are not enrolled in Medicare.			
<input type="checkbox"/> Fallon Direct (HMO) <input type="checkbox"/> Fallon Select (HMO) <input type="checkbox"/> Harvard Pilgrim Independence (POS) <input type="checkbox"/> Harvard Pilgrim Primary Choice (HMO)	<input type="checkbox"/> Health New England (HMO) <input type="checkbox"/> NHP Prime–Neighborhood Health Plan (HMO) <input type="checkbox"/> Tufts Health Plan Navigator (POS) <input type="checkbox"/> Tufts Health Plan Spirit (HMO-type)	<input type="checkbox"/> UniCare State Indemnity/Basic CIC: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UniCare Community Choice (PPO-type) <input type="checkbox"/> UniCare/PLUS (PPO-type)	<b>Non-Medicare Coverage Election</b> <input type="checkbox"/> Individual <input type="checkbox"/> Family

SPOUSE/DEPENDENT INFORMATION (See instructions on back)							
For Changes Only	LAST NAME	FIRST NAME	MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	

FORMER SPOUSE INFORMATION – If Listed Above				Date of Divorce: / /
Are you remarried? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of your remarriage: / /	Has your former spouse remarried? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of former spouse's remarriage: / /	
Address: Street		City	State	Zip

SIGNATURE REQUIRED	<b>AUTHORIZATION</b> – I have read the instructions on the reverse side of this form and direct my pension authority to deduct from my pension check the amount required for the coverage I have selected. I understand that my health insurance coverage elections are binding for the duration of the plan year and that I may only enroll in health insurance or change my coverage elections during the plan year if I experience a qualifying status change (examples include marriage, adoption/birth of a child, death of a dependent, and involuntary loss of other coverage). I understand that the GIC must receive any required documentation within 60 days of the event.			
	Signature of Applicant: _____		Date: _____	
Signature of Authorized Official: _____		Date: _____		

For GIC Use Only	Entered	Verified	Political Subdivision
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(See over for Form-RS instructions)

## GIC RETIREE/SURVIVOR ENROLLMENT AND CHANGE FORM (FORM-RS) INSTRUCTIONS

Use this Form-RS to make GIC health plan changes for a qualifying status change, at Annual Enrollment, and for enrolling in GIC health insurance for the first time at retirement.

**For an overview of your GIC health insurance benefit options, see the GIC Benefit Decision Guide [www.mass.gov/gic/bdgs](http://www.mass.gov/gic/bdgs).**

### Deadlines and Required Documentation

- **Required documentation:** To add a spouse or dependent to coverage, documentation is required. Visit our website for the Required Documentation list: [www.mass.gov/gic/forms](http://www.mass.gov/gic/forms).
- If you and/or your spouse is **Medicare eligible** and **not already enrolled in GIC Medicare** coverage, the following documentation must accompany this form:
  - Photocopy of your Medicare Card (include a copy of spouse's card if applicable).
  - Photocopy of your latest 1099 or the Benefit Verification letter printed from Social Security's website stating how your monthly Part B premium is paid (e.g., you are being directly billed by Social Security or it is being deducted from your Social Security check). Include this same documentation for your spouse, if applicable.
- If you and/or your spouse are over age 65 and **not eligible for Medicare** and have not already provided the following documentation to the GIC, it must accompany this form:
  - Social Security Denial letter stating that you and/or your spouse are not eligible for Medicare Part A for free.
- **Annual Enrollment:** Completed paperwork and required documentation must be received by the GIC (retirees and survivors) by the end of the Annual Enrollment period.
- **Qualifying Status Change:** Retirees and survivors with a qualifying status change must submit completed forms with proof of the qualifying status change (e.g., address change) to the GIC within 60 days of the qualifying event.

**Enrolling in health insurance for the first time:** Use this form in addition to Form-1A to enroll at retirement in GIC health insurance for the first time. You must send with this form a copy of the letter from your retirement board approving your retirement. State retirees only be aware that your health insurance election includes basic life insurance.

### Retiree and Spouse Coverage if Under and Over Age 65

If you (the retiree), your spouse or other covered dependent is younger than age 65, the person or people under age 65 will continue to be covered under a Non-Medicare plan until you and/or he/she becomes eligible for Medicare. Be sure to choose "individual" Non-Medicare coverage if only covering one Non-Medicare family member; select "family" Non-Medicare coverage if covering two or more Non-Medicare family members.

If this is the case, you must enroll in one of the pairs of plans listed below:

Non-Medicare Plan	Medicare Plan
Fallon Health Direct Care	Fallon Senior Plan
Fallon Health Select Care	Fallon Senior Plan
Harvard Pilgrim Independence Plan	Harvard Pilgrim Medicare Enhance
Harvard Pilgrim Primary Choice Plan	Harvard Pilgrim Medicare Enhance
Health New England	Health New England MedPlus
Tufts Health Plan Navigator	Tufts Health Plan Medicare Complement
Tufts Health Plan Navigator	Tufts Health Plan Medicare Preferred
Tufts Health Plan Spirit	Tufts Health Plan Medicare Complement
Tufts Health Plan Spirit	Tufts Health Plan Medicare Preferred
UniCare State Indemnity Plan/Basic	UniCare State Indemnity Plan/Medicare Extension (OME)
UniCare State Indemnity Plan/Community Choice	UniCare State Indemnity Plan/Medicare Extension (OME)
UniCare State Indemnity Plan/PLUS	UniCare State Indemnity Plan/Medicare Extension (OME)

Note that the above options do not apply to Retired Municipal Teachers (GIC RMTs). See the *Benefit Decision Guide* or our website for GIC RMT options.

**If Enrolling in Fallon Senior Plan:** If enrolling in this Medicare plan, the GIC will notify the plan to forward their Medicare application to you to complete and return.

**If Currently Enrolled in Fallon Senior Plan or Tufts Medicare Preferred and Changing Plans:** If you are currently enrolled in one of these GIC Medicare Plan options and are changing plans, you and your covered spouse, if applicable, must dis-enroll from the plan. Please also complete and return to the GIC a Medicare Advantage Plan dis-enrollment form, available at [www.mass.gov/gic/forms](http://www.mass.gov/gic/forms).

**Form and Documentation Submission:** Return completed form and documentation to the GIC, P.O. Box 8747, Boston, MA 02114